

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
ISM 9/59

1  
2  
13855  
13829  
M  
66  
1  
0  
1

1  
2  
13855  
13829  
M  
66  
1  
0  
1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Indian Head.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>135 Mattingly Ave.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>SARAH</b> First <b>FRANCES</b> Middle <b>BUSHEY</b> Last		4. DATE OF DEATH <b>Dec</b> Month <b>19</b> Day <b>1961</b> Year	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/31/83</b>
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACK PATTERSON</b>		14. MOTHER'S MAIDEN NAME <b>MARGARET LOVELESS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>ALBERT BUSHEY, INDIAN HEAD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>uremia</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>CUA</b> DUE TO (c) <b>hypertension</b>		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>23 days</b> <b>10 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>27 Nov 1961</b> to <b>19 Dec 1961</b> , that (I) (we) lost the deceased alive on <b>19 Dec 1961</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>A. Wooddy</b>		22b. DATE SIGNED <b>19 Dec 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODDY</b>		22d. ADDRESS <b>LA PLATA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>POHICK CEM.</b>		23d. LOCATION (City, town, or county) (State) <b>POHICK, VA.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunter Funeral Home, WILDORE, MD.</b>		25a. REC'D BY REGISTRAR <b>DEC 22 '61</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE	





1988

(M)

Location and person responsible for verification.

Five in two.

X 12/1  
X  
X

Charles J. Taylor, M.D.

TO BE RETAINED BY HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13857

13831

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lz Plata</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>WALDORF</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BABY BOY</u> First Middle Last <u>Estep.</u>		4. DATE OF DEATH Month <u>12</u> Day <u>16</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-15-61</u>
9. AGE (In years last birthday) <u>7</u> yrs.		10. IF UNDER 1 YEAR: Months <u>7</u> Days <u>1</u> Hours <u>1</u> Min. <u>1</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Lz Plata Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James L. Estep</u>		14. MOTHER'S MAIDEN NAME <u>Dorothy Mae Gough</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Dorothy Mae Estep</u> Address <u>Waldorf Maryland</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity 2#8 oz</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Gestation 28 wks.</u> DUE TO (c) <u>—</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-15-61</u> to <u>12-16-61</u> , that (I) (we) last saw the deceased alive on <u>12-16-61</u> , and that death occurred at <u>7 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>E. J. EDELEN</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>E. J. EDELEN MD</u>		22d. ADDRESS <u>Lz Plata Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-18-61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Peters</u>		23d. LOCATION (City, town, or county) (State) <u>Waldorf Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hunt Funeral Home, Waldorf, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 19 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles L. Prince</u>			

2066202XVI

13827

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS - BOSTON  
OFFICE OF REGISTRAR - BOSTON

13827

13827

13827

13827

13827

13827

13827

13827

13827

13827

13827

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

13858 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13832

1. PLACE OF DEATH a. COUNTY <u>Charles</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>LA PLATA</u> c. LENGTH OF STAY in 1b <u>30 min.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Physician's Memorial Hosp.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>x Waldorf</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>CHARL</u>		First Middle Last <u>Geppert</u>		4. DATE OF DEATH Month <u>12</u> Day <u>22</u> Year <u>1961</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 8, 1902</u>	9. AGE (In years last birthday) <u>59</u> yrs.	IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ODD JOBS</u>		11. BIRTHPLACE (State or foreign country) <u>Poland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Carl Geppert</u>					
14. MOTHER'S MAIDEN NAME <u>Emma Thom</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)					
16. SOCIAL SECURITY NO. <u>220-28-7224</u>		17. INFORMANT Address <u>219 Maryland Wash, DC</u>					
18. CAUSE OF DEATH [Enter only one cause for line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>FRAC SKULL</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>PEDESTRIAN HIT BY Auto</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>12-23-61</u>				INTERVAL BETWEEN ONSET AND DEATH <u>12-23-61</u> <u>12-23-61</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Hit by Auto (Pedestrian)</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>6</u> p.m. <u>12-22</u> <u>1961</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>AWAY</u>			
20f. (City or town) <u>WALDORF</u>		(County) <u>CHARS</u> (State) <u>MD</u>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>[Signature]</u>		M.D. <u>[Signature]</u>		DATE SIGNED <u>12-23-61</u>			
EXAMINER'S NAME (Type) <u>E. J. EDLEN</u>		Address (Street, city, town, or county) <u>Huntt Funeral Home, Waldorf, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12-27-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Washington National</u>			
22d. LOCATION (City, town, or country) <u>Switzland</u>		(State) <u>Maryland</u>					
23. FUNERAL DIRECTOR <u>Huntt Funeral Home, Waldorf, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 29 '61</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

10000

in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

13859

13833

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>10m</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Samuel</b> First <b>Linwood</b> Middle <b>HART</b> Last				4. DATE OF DEATH <b>December 22</b> 19 <b>61</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>22 June 1879</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Net Telegrapher</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Western Union Corp. Texas</b>			
11. BIRTHPLACE (State or foreign country) <b>Texas</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>Benjamin Hart</b>				14. MOTHER'S MAIDEN NAME <b>Carrie Harris</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>517-09-9402</b>			
17. INFORMANT <b>Thomas A Hart</b> Address <b>1519-17th St SE</b>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertensive heart disease</b> DUE TO (c) <b>Arteriosclerosis</b> DUE TO							INTERVAL BETWEEN ONSET AND DEATH <b>1mm</b> <b>4 years</b> <b>10 yrs.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>6 Nov</b> 19 <b>61</b> , to <b>22 Dec</b> 19 <b>61</b> , that (I) (we) lost the deceased on <b>22 Dec</b> 19 <b>61</b> , and that death occurred on <b>22 Dec</b> 19 <b>61</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Arthur O. Woody</b> M.D.				22b. DATE SIGNED <b>DEC 27 '61</b>			
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY</b>				22d. ADDRESS <b>LA PLATA MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/26/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Nanjemoy Baptist Church</b>		23d. LOCATION (City, town, or county) (State) <b>Nanjemoy, Charles Co., Md.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b> ADDRESS <b>Archart Funeral Home, Inc. La Plata, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>	

1

3

66

1

0

1

11722

CERTIFICATE OF DEATH

1. Name of deceased: \_\_\_\_\_

2. Sex: \_\_\_\_\_

3. Age: \_\_\_\_\_

4. Date of birth: \_\_\_\_\_

5. Place of birth: \_\_\_\_\_

6. Date of death: \_\_\_\_\_

7. Time of death: \_\_\_\_\_

8. Cause of death: \_\_\_\_\_

9. Place of death: \_\_\_\_\_

10. Signature of physician: \_\_\_\_\_

11. Signature of registrar: \_\_\_\_\_

12. Signature of informant: \_\_\_\_\_

13. Date of registration: \_\_\_\_\_

14. Place of registration: \_\_\_\_\_

15. Name of registrar: \_\_\_\_\_

16. Name of informant: \_\_\_\_\_

17. Name of physician: \_\_\_\_\_

18. Name of hospital: \_\_\_\_\_

19. Name of doctor: \_\_\_\_\_

20. Name of nurse: \_\_\_\_\_

21. Name of pharmacist: \_\_\_\_\_

22. Name of dentist: \_\_\_\_\_

23. Name of veterinarian: \_\_\_\_\_

24. Name of other health professional: \_\_\_\_\_

25. Name of other health professional: \_\_\_\_\_

26. Name of other health professional: \_\_\_\_\_

27. Name of other health professional: \_\_\_\_\_

28. Name of other health professional: \_\_\_\_\_

29. Name of other health professional: \_\_\_\_\_

30. Name of other health professional: \_\_\_\_\_

31. Name of other health professional: \_\_\_\_\_

32. Name of other health professional: \_\_\_\_\_

33. Name of other health professional: \_\_\_\_\_

34. Name of other health professional: \_\_\_\_\_

35. Name of other health professional: \_\_\_\_\_

36. Name of other health professional: \_\_\_\_\_

37. Name of other health professional: \_\_\_\_\_

38. Name of other health professional: \_\_\_\_\_

39. Name of other health professional: \_\_\_\_\_

40. Name of other health professional: \_\_\_\_\_

41. Name of other health professional: \_\_\_\_\_

42. Name of other health professional: \_\_\_\_\_

43. Name of other health professional: \_\_\_\_\_

44. Name of other health professional: \_\_\_\_\_

45. Name of other health professional: \_\_\_\_\_

46. Name of other health professional: \_\_\_\_\_

47. Name of other health professional: \_\_\_\_\_

48. Name of other health professional: \_\_\_\_\_

49. Name of other health professional: \_\_\_\_\_

50. Name of other health professional: \_\_\_\_\_

51. Name of other health professional: \_\_\_\_\_

52. Name of other health professional: \_\_\_\_\_

53. Name of other health professional: \_\_\_\_\_

54. Name of other health professional: \_\_\_\_\_

55. Name of other health professional: \_\_\_\_\_

56. Name of other health professional: \_\_\_\_\_

57. Name of other health professional: \_\_\_\_\_

58. Name of other health professional: \_\_\_\_\_

59. Name of other health professional: \_\_\_\_\_

60. Name of other health professional: \_\_\_\_\_

61. Name of other health professional: \_\_\_\_\_

62. Name of other health professional: \_\_\_\_\_

63. Name of other health professional: \_\_\_\_\_

64. Name of other health professional: \_\_\_\_\_

65. Name of other health professional: \_\_\_\_\_

66. Name of other health professional: \_\_\_\_\_

67. Name of other health professional: \_\_\_\_\_

68. Name of other health professional: \_\_\_\_\_

69. Name of other health professional: \_\_\_\_\_

70. Name of other health professional: \_\_\_\_\_

71. Name of other health professional: \_\_\_\_\_

72. Name of other health professional: \_\_\_\_\_

73. Name of other health professional: \_\_\_\_\_

74. Name of other health professional: \_\_\_\_\_

75. Name of other health professional: \_\_\_\_\_

76. Name of other health professional: \_\_\_\_\_

77. Name of other health professional: \_\_\_\_\_

78. Name of other health professional: \_\_\_\_\_

79. Name of other health professional: \_\_\_\_\_

80. Name of other health professional: \_\_\_\_\_

81. Name of other health professional: \_\_\_\_\_

82. Name of other health professional: \_\_\_\_\_

83. Name of other health professional: \_\_\_\_\_

84. Name of other health professional: \_\_\_\_\_

85. Name of other health professional: \_\_\_\_\_

86. Name of other health professional: \_\_\_\_\_

87. Name of other health professional: \_\_\_\_\_

88. Name of other health professional: \_\_\_\_\_

89. Name of other health professional: \_\_\_\_\_

90. Name of other health professional: \_\_\_\_\_

91. Name of other health professional: \_\_\_\_\_

92. Name of other health professional: \_\_\_\_\_

93. Name of other health professional: \_\_\_\_\_

94. Name of other health professional: \_\_\_\_\_

95. Name of other health professional: \_\_\_\_\_

96. Name of other health professional: \_\_\_\_\_

97. Name of other health professional: \_\_\_\_\_

98. Name of other health professional: \_\_\_\_\_

99. Name of other health professional: \_\_\_\_\_

100. Name of other health professional: \_\_\_\_\_

MADE IN U.S.A.

CHINA

1  
M  
66  
1  
0

13860

13834

13860

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD</b> b. COUNTY <b>CHARS</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X COBB ISLAND</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ASSOCIATES MEM.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>DELL B HUNTER</b>				4. DATE OF DEATH Month Day Year <b>12 2 1961</b>			
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-13-83</b>	
9. AGE (In years last birthday) <b>78</b> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk - Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>(Unknown) Grove</b>				14. MOTHER'S MAIDEN NAME <b>Isadora Kaler</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Mr. Herbert A. McCullough - Newpew</b> Address <b>1321 Saulter Road, Birmingham Alabama</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 CORONARY OCCLUSION</b> DUE TO <b>GEN ART SCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GEN ART SCLEROSIS</b> DUE TO (c) <b>GEN ART SCLEROSIS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12-1-61</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1958</b> 19 to <b>12-2</b> 1961, that (I) (we) last saw the deceased alive on <b>12-2</b> 1961 and that death occurred <b>3:45</b> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <b>E. J. EDELEN</b>				22b. DATE SIGNED <b>12-3-61</b>		22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN</b>	
22d. ADDRESS <b>La Plata Md</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12/5/1961</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Mt. Lebanon, Pennsylvania</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Archart Funeral Home, Inc.</b> ADDRESS <b>La Plata, Md.</b>				25a. REC'D BY REGISTRAR <b>DEC 5 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur S. Smith</b>	

WARRANT FOR THE DEATH OF  
JAMES EARL RAY  
FUGITIVE FROM JUSTICE  
CHARGE: MURDER OF MARTIN LUTHER KING, JR.  
ARRESTED BY: [illegible]  
DATE: [illegible]

02280

(M)

[Faint, mostly illegible handwritten text, possibly a letter or report, covering the majority of the page.]

1  
V4  
13861  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH  
13835

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>				c. LENGTH OF STAY IN 1b <b>12 hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Physicians Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>JAMES CHARLES LACEY</b>				4. DATE OF DEATH <b>December 18 1961</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/6/84</b>	
9. AGE (In years last birthday) <b>77</b> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FIRE FIGHTER</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>FIREMAN</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>CHARLES LACEY</b>				14. MOTHER'S MAIDEN NAME <b>ALVINA DICKER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>EVELYN LACEY, LA PLATA, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>155.1 respiration collapse</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>pneumonia due to metastasis to lungs</b> DUE TO (c) <b>Carcinoma of Gall bladder</b>				INTERVAL BETWEEN ONSET AND DEATH <b>15 min</b> <b>3 days</b> <b>9 min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>June 1961</b> to <b>18 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>18 Dec 1961</b> , and that death occurred <b>3:15 A.M.</b> from the causes and on the date stated above.							
22a. SIGNATURE <b>Dr. Woody. MD</b>				22b. DATE SIGNED <b>18 Dec 61</b>		22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY MD</b>	
22d. ADDRESS <b>LA PLATA, MARYLAND</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-20-61</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT REST</b>		23d. LOCATION (City, town, or county) (State) <b>LA PLATA, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WILDORE, MD.</b>				25a. REC'D BY REGISTRAR <b>DEC 21 '61</b>		25b. REGISTRAR'S SIGNATURE <b>Arthur O. Woody</b>	

(M)

(I)

0

1

in by the funeral director, and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1965

(1)

(1)



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 13836

13862

1. PLACE OF DEATH o. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Florida</u> b. COUNTY <u>Brevard</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac Heights</u>	c. LENGTH OF STAY IN 1b <u>7 mos.</u>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eau Gallie (Eau Gallie)</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>88 Circle Ave</u>		d. STREET ADDRESS <u>1624 Sarno Road 48X-3</u>	
3. NAME OF DECEASED (Type or print) First <u>Older</u> Middle <u>LOUE</u> Last <u>LIEBISCH</u>		4. DATE OF DEATH Month <u>Dec.</u> Day <u>19</u> Year <u>1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 16, 1897</u>
9. AGE (In years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Orchard, Texas.</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Fred. O. Ferris</u>	
14. MOTHER'S MAIDEN NAME <u>Lucy Kerrick</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY NO. <u>213-22-2478</u>		17. INFORMANT <u>Mrs. John R. Jenkins</u> Address <u>88 Circle Ave Potomac Heights, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Stomach</u> DUE TO (b) <u>151 X</u> DUE TO (c) <u>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.</u> INTERVAL BETWEEN ONSET AND DEATH <u>9 mos.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept. 15, 1961</u> , to <u>Dec 19, 1961</u> , that I last saw the deceased alive on <u>Dec 11, 1961</u> , and that death occurred at <u>7:00 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank G. Susan</u> M.D.		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u> DATE SIGNED <u>12-19-61</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>		<u>Indian Head, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>12-21-61</u>	<u>Fairview</u>	<u>Culpeper Va.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Richard M. L. Plate M.D.</u>		24a. REC'D BY REGISTRAR <u>DATE</u> <u>EC 26 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

...the ... of ...

1  
FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, end in any event within 72 hours after death.

VS. A15ME  
5M 7/59

13863  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
13837

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryans Road</b>		c. LENGTH OF STAY IN 1b <b>16 X 2</b>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince George</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Billingsley Road</b>		e. STREET ADDRESS <b>Piscataway Md (Rural)</b>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <b>James Joseph Smith</b>		First <b>James</b>		Middle <b>Joseph</b>		Last <b>Smith</b>		4. DATE OF DEATH <b>12-22-61</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-15-40</b>		9. AGE (In years last birthday) <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machine Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>USGovt. N.P.P.</b>		11. BIRTHPLACE (State or foreign country) <b>Piscataway Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
13. FATHER'S NAME <b>Wesley Smith</b>		14. MOTHER'S MAIDEN NAME <b>Geneva Munson</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Yes</b>		17. INFORMANT <b>Thomas L; Munson-Uncle. Washington D.C.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple-Extreme</b> DUE TO (b) <b>Auto Accident</b> DUE TO (c) <b>Auto Accident</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto Accident-Car overturned</b>		20c. TIME OF INJURY Month, Day, Year <b>8:30PM 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	
20f. (City or town) <b>Bryans Road Md</b>		20g. (County) <b>Charles Co.</b>		20h. (State) <b>Charles Co.</b>		20i. (City or town) <b>Bryans Road Md</b>		20j. (County) <b>Charles Co.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <b>Natural causes</b> <input type="checkbox"/> <b>Accident</b> <input checked="" type="checkbox"/> <b>Suicide</b> <input type="checkbox"/> <b>Homicide</b> <input type="checkbox"/> <b>Undetermined manner</b> <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>12-23-61</b>	
ACTUAL SIGNATURE <b>James E. Andrews MD.</b>		EXAMINER'S NAME (Type) <b>James E. Andrews MD.</b>		Address (Street, city, town, or county) <b>Piscataway Md.</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>12-26-61</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Marys</b>		22d. LOCATION (City, town, or country) <b>Piscataway Md.</b>		22e. LOCATION (City, town, or country) <b>Piscataway Md.</b>		22f. LOCATION (City, town, or country) <b>Piscataway Md.</b>		22g. LOCATION (City, town, or country) <b>Piscataway Md.</b>	
23. FUNERAL DIRECTOR <b>Hunt Funeral Home, Waldorf, Md.</b>		23a. REC'D BY REGISTRAR <b>DEC 27 '61</b>		23b. REGISTRAR'S SIGNATURE <b>William S. Plummer</b>		23c. REGISTRAR'S SIGNATURE <b>William S. Plummer</b>		23d. REGISTRAR'S SIGNATURE <b>William S. Plummer</b>	

MEDICAL CERTIFICATION

MAINTAIN A RECORD OF ALL  
MEDICAL EXAMINATIONS AND TREATMENTS  
AND THE RESULTS THEREOF  
IN THE FOLLOWING MANNER  
1. NAME  
2. AGE  
3. SEX  
4. OCCUPATION  
5. ADDRESS  
6. DATE OF EXAMINATION  
7. NAME OF PHYSICIAN  
8. NAME OF HOSPITAL  
9. NAME OF CLINIC  
10. NAME OF LABORATORY  
11. NAME OF X-RAY DEPARTMENT  
12. NAME OF RADIOLOGICAL DEPARTMENT  
13. NAME OF PATHOLOGICAL DEPARTMENT  
14. NAME OF BACTERIOLOGICAL DEPARTMENT  
15. NAME OF CHEMICAL DEPARTMENT  
16. NAME OF PHYSIOLOGICAL DEPARTMENT  
17. NAME OF ANATOMICAL DEPARTMENT  
18. NAME OF HISTOLOGICAL DEPARTMENT  
19. NAME OF CYTOLOGICAL DEPARTMENT  
20. NAME OF MICROSCOPICAL DEPARTMENT  
21. NAME OF RADIOLOGICAL DEPARTMENT  
22. NAME OF RADIOLOGICAL DEPARTMENT  
23. NAME OF RADIOLOGICAL DEPARTMENT  
24. NAME OF RADIOLOGICAL DEPARTMENT  
25. NAME OF RADIOLOGICAL DEPARTMENT  
26. NAME OF RADIOLOGICAL DEPARTMENT  
27. NAME OF RADIOLOGICAL DEPARTMENT  
28. NAME OF RADIOLOGICAL DEPARTMENT  
29. NAME OF RADIOLOGICAL DEPARTMENT  
30. NAME OF RADIOLOGICAL DEPARTMENT  
31. NAME OF RADIOLOGICAL DEPARTMENT  
32. NAME OF RADIOLOGICAL DEPARTMENT  
33. NAME OF RADIOLOGICAL DEPARTMENT  
34. NAME OF RADIOLOGICAL DEPARTMENT  
35. NAME OF RADIOLOGICAL DEPARTMENT  
36. NAME OF RADIOLOGICAL DEPARTMENT  
37. NAME OF RADIOLOGICAL DEPARTMENT  
38. NAME OF RADIOLOGICAL DEPARTMENT  
39. NAME OF RADIOLOGICAL DEPARTMENT  
40. NAME OF RADIOLOGICAL DEPARTMENT  
41. NAME OF RADIOLOGICAL DEPARTMENT  
42. NAME OF RADIOLOGICAL DEPARTMENT  
43. NAME OF RADIOLOGICAL DEPARTMENT  
44. NAME OF RADIOLOGICAL DEPARTMENT  
45. NAME OF RADIOLOGICAL DEPARTMENT  
46. NAME OF RADIOLOGICAL DEPARTMENT  
47. NAME OF RADIOLOGICAL DEPARTMENT  
48. NAME OF RADIOLOGICAL DEPARTMENT  
49. NAME OF RADIOLOGICAL DEPARTMENT  
50. NAME OF RADIOLOGICAL DEPARTMENT  
51. NAME OF RADIOLOGICAL DEPARTMENT  
52. NAME OF RADIOLOGICAL DEPARTMENT  
53. NAME OF RADIOLOGICAL DEPARTMENT  
54. NAME OF RADIOLOGICAL DEPARTMENT  
55. NAME OF RADIOLOGICAL DEPARTMENT  
56. NAME OF RADIOLOGICAL DEPARTMENT  
57. NAME OF RADIOLOGICAL DEPARTMENT  
58. NAME OF RADIOLOGICAL DEPARTMENT  
59. NAME OF RADIOLOGICAL DEPARTMENT  
60. NAME OF RADIOLOGICAL DEPARTMENT  
61. NAME OF RADIOLOGICAL DEPARTMENT  
62. NAME OF RADIOLOGICAL DEPARTMENT  
63. NAME OF RADIOLOGICAL DEPARTMENT  
64. NAME OF RADIOLOGICAL DEPARTMENT  
65. NAME OF RADIOLOGICAL DEPARTMENT  
66. NAME OF RADIOLOGICAL DEPARTMENT  
67. NAME OF RADIOLOGICAL DEPARTMENT  
68. NAME OF RADIOLOGICAL DEPARTMENT  
69. NAME OF RADIOLOGICAL DEPARTMENT  
70. NAME OF RADIOLOGICAL DEPARTMENT  
71. NAME OF RADIOLOGICAL DEPARTMENT  
72. NAME OF RADIOLOGICAL DEPARTMENT  
73. NAME OF RADIOLOGICAL DEPARTMENT  
74. NAME OF RADIOLOGICAL DEPARTMENT  
75. NAME OF RADIOLOGICAL DEPARTMENT  
76. NAME OF RADIOLOGICAL DEPARTMENT  
77. NAME OF RADIOLOGICAL DEPARTMENT  
78. NAME OF RADIOLOGICAL DEPARTMENT  
79. NAME OF RADIOLOGICAL DEPARTMENT  
80. NAME OF RADIOLOGICAL DEPARTMENT  
81. NAME OF RADIOLOGICAL DEPARTMENT  
82. NAME OF RADIOLOGICAL DEPARTMENT  
83. NAME OF RADIOLOGICAL DEPARTMENT  
84. NAME OF RADIOLOGICAL DEPARTMENT  
85. NAME OF RADIOLOGICAL DEPARTMENT  
86. NAME OF RADIOLOGICAL DEPARTMENT  
87. NAME OF RADIOLOGICAL DEPARTMENT  
88. NAME OF RADIOLOGICAL DEPARTMENT  
89. NAME OF RADIOLOGICAL DEPARTMENT  
90. NAME OF RADIOLOGICAL DEPARTMENT  
91. NAME OF RADIOLOGICAL DEPARTMENT  
92. NAME OF RADIOLOGICAL DEPARTMENT  
93. NAME OF RADIOLOGICAL DEPARTMENT  
94. NAME OF RADIOLOGICAL DEPARTMENT  
95. NAME OF RADIOLOGICAL DEPARTMENT  
96. NAME OF RADIOLOGICAL DEPARTMENT  
97. NAME OF RADIOLOGICAL DEPARTMENT  
98. NAME OF RADIOLOGICAL DEPARTMENT  
99. NAME OF RADIOLOGICAL DEPARTMENT  
100. NAME OF RADIOLOGICAL DEPARTMENT

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 9/59

1  
13864  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13838

1. PLACE OF DEATH o. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PIATA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X WALDORF</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSP.</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Rebecca M. SWANN</b>		4. DATE OF DEATH Month <b>12</b> Day <b>30</b> Year <b>1961</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 29, 1904</b>
9. AGE (In years last birthday) <b>57</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOSEPH E. WELCH</b>		14. MOTHER'S MAIDEN NAME <b>DELPHIA GOLDSMITH</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>1</b>	
17. INFORMANT <b>MRS. JAMES KERSEY, WALDORF, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>DATA Not Known</b> <b>159X</b> DUE TO <b>CA. HE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>3 yrs</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Cerebral Vascular Disease</b> INTERVAL BETWEEN ONSET AND DEATH <b>12-29-61</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1-10-55</b> to <b>12-30-61</b> , that (I) (we) last saw the deceased alive on <b>12-30-1961</b> , and that death occurred at <b>6</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>E. J. EDELEN</b>		22d. ADDRESS <b>La Plata Ave</b>	
22e. MED. PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>JAN. 2, 1962</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ST PETERS</b>		23d. LOCATION (City, town, or county) (State) <b>WALDORF, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, WALDORF, MD.</b>		25a. REC'D BY REGISTRAR DATE <b>JAN 3 '62</b>	
25b. REGISTRAR'S SIGNATURE <b>Clinton S. Thomas</b>			

1926

(M)

(1)

CHIEF OF BUREAU

Secretary

1  
FOR STATE  
HEALTH DEPT.

any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 7/59

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13865

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13839

1. PLACE OF DEATH a. COUNTY <b>Charles</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bryans Road Md</b> c. LENGTH OF STAY in lb <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Billingsley Road</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Bryans Road Md.</b> b. COUNTY <b>Charles</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bryans Road</b> d. STREET ADDRESS <b>1</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>Harold Washington</b> First Middle Last				4. DATE OF DEATH Month Day Year <b>12-22-61</b> <b>19</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1, 1940</b>	
9. AGE (in years last birthday) <b>21</b>		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Bryans Road Md</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Ballard Washington</b> <b>Mattox Washington</b>				14. MOTHER'S MAIDEN NAME <b>Cecelia Holt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>U.S.A.F.</b>		17. INFORMANT <b>Mrs. Cecila Washington -Mother-Bryans Road, Md.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Injuries Multiple - Extreme</b> <b>822X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Auto Accident</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car overturned-Billingsly Road-Near Bryans Road Md</b>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>8:30 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Bryans Road Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>James E. Andrews</b> EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Indian Head Md</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>12-28-61</b>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or country) (State) <b>Arlington Va</b>	
23. FUNERAL DIRECTOR <b>Carmes &amp; Matthews</b> ADDRESS <b>3614-14" St. N.W. Wash. DC</b>				24a. REC'D BY REGISTRAR <b>DEC 28 '61</b>		24b. REGISTRAR'S SIGNATURE <b>Charles L. House</b>	

MEDICAL CERTIFICATION

100-100000  
BULKY UNIT

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13840

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>CHARLES</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>18 days.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>PHYSICIANS MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Maude</b> Middle <b>Wedding</b> Last <b>Wedding</b>		4. DATE OF DEATH Month <b>Dec</b> Day <b>28</b> Year <b>1961</b>	
5. SEX <b>female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/12/93</b>
9. AGE (In years lost birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.	11. IF UNDER 24 HRS. Months <b>68</b> Days <b>68</b> Hours <b>68</b> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>DOMESTIC</b>	
11. BIRTHPLACE (State or foreign country) <b>DISTRICT OF COLUMBIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ANTHONY WYNN</b>		14. MOTHER'S MAIDEN NAME <b>ISABELLE SPARK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Joseph Wedding, INDIAN HEAD, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemorrhage, sigmoid,</b> <b>153.3</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma sigmoid</b> DUE TO (c) <b>3 mcs.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 m</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>29 Oct 1961</b> to <b>28 Dec 1961</b> , that (I) (we) last saw the deceased alive on <b>27 Dec 1961</b> , and that death occurred at <b>3A M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>Arthur O. Woody, MD</b> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>28 Dec 61</b>	
22c. PHYSICIAN'S NAME (Type) <b>ARTHUR O. WOODY, MD</b>		22d. ADDRESS <b>LA PLATA, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>12-30-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>MT REST</b>		23d. LOCATION (City, town, or county) (State) <b>LA PLATA, MD.</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, MD.</b>		25a. REC'D BY REGISTRAR <b>DATE JAN 3 '62</b>	
ADDRESS		25b. REGISTRAR'S SIGNATURE <b>Arthur O. Woody</b>	

M

66

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH  
DIVISION OF PUBLIC HEALTH  
OFFICE OF VITAL RECORDS  
DECLARATION OF DEATH

1955

10-10

Name of Deceased		Date of Birth		Sex		Race		Religion		Marital Status		Occupation		Cause of Death		Place of Death		Date of Death		Time of Death		Signature of Registrar		Signature of Physician		Signature of Medical Examiner	
John Doe		10/10/1910		Male		White		Roman Catholic		Married		Teacher		Heart Disease		Home		October 10, 1955		10:00 AM		[Signature]		[Signature]		[Signature]	



TO BE RETAINED BY THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
TSM 9/59

13867

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

13841

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. LENGTH OF STAY IN 1b <b>Life</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Magaline</b> Last <b>Wilkerson</b>		4. DATE OF DEATH Month <b>December 19,</b> Day <b>19</b> Year <b>1961</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>October 13, 1872</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Domestic</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Walter Willett</b>		14. MOTHER'S MAIDEN NAME <b>Mary Jane Hicks</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, go, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Le Moine A. Wilkerson Sr.,</b>		Address <b>Waldorf, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIAC APOPLEXY</b> <b>434.4</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Demility</b> DUE TO (c) <b>TERMINAL PNEUMONIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Dec - 18</b> <b>1961</b> to <b>Dec - 19</b> <b>1961</b> , that (I) (we) last saw the deceased alive on <b>Dec - 18</b> <b>1961</b> , and that death occurred on <b>108 P</b> <b>M</b> , from the causes and on the date stated above.			
22a. SIGNATURE <b>George Weber M.D.</b>		22b. DATE SIGNED <b>12-20-61</b>	
22c. PHYSICIAN'S NAME (Type) <b>George Weber M.D.</b>		22d. ADDRESS <b>Waldorf, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>12-22-61</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetery</b>		23d. LOCATION (City, town, or county) (State) <b>Waldorf, Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 22 '61</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles S. Finner</b>			



CERTIFICATE OF DEATH

Reg. Dist. No. 13842

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bryans Road</u>	
c. LENGTH OF STAY IN 1b <u>19 yrs</u>		d. STREET ADDRESS <u>Rt 1 Box 131A Indian Head</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Samuel</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>17</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January? 1895</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ODD JOBS</u>	
11. BIRTHPLACE (State or foreign country) <u>Wicomico, Ches. Co. Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>John Williams</u>		14. MOTHER'S MAIDEN NAME <u>Ida May Smallwood</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-18-7145</u>	
17. INFORMANT <u>Wife Mrs. Hattie Williams</u>		Address <u>Rt 1 Box 131A, Indian Head Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Heart Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>10 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Nat while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan</u> , 19 <u>51</u> , to <u>Dec. 16</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Dec 16</u> , 19 <u>61</u> , and that death occurred at <u>11:55 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Sassen</u>		DATE SIGNED <u>12/17/61</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Sassen M.D.</u>		ADDRESS (Street, city or town, state) <u>5 Indian Head Ave Indian Head, Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>12-20-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>ST JOSEPH'S</u>	22d. LOCATION (City, town, or county) (State) <u>POMFRET, M.D.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Waldorf, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>DEC 21 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 of this certificate is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

